STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY ARNOLD SCHWARZENEGGER, *Governor*

EMERGENCY MEDICAL SERVICES AUTHORITY
1930 9th STREET
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(916) 322-4336 FAX (916) 324-2875

June 1, 2005

EMS National Scope of Practice Model Project
c/o NASEMSD
201 Park Washington Court
Falls Church, VA 22046-4527

Please accept the attached comments for Version 2.0 of the National Scope of Practice Model and thank you for the opportunity to provide comments.

These comments come from the California EMT-II Task Force which is made up of a cross section of emergency medical services (EMS) constituents from California which has been tasked by California EMS Authority to review and comment on Version 2.0 of the National Scope of Practice Model. The members of the EMT-II Task Force consist of EMS educators, fire chief representatives, labor organizations for both public and private EMS providers, ambulance association members, EMS administrators, EMS medical directors, all from both rural and urban EMS systems, law enforcement agencies, and hospital associations. The International Association of Fire Chiefs also supports these comments.

As the Interim Director of the EMS Authority, I will be submitting these comments to California's Commission on EMS for their comment and approval. In the event that the Commission on EMS wishes to submit additional comments, I will forward those comments directly.

If you have any questions, please call me at (916) 322-4336.

Sincerely,

Richard E. Watson
Interim Director

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May 27, 2005

Sean Trask
California Emergency Medical Services Authority
1930 9th Street
Sacramento. Ca. 95814

Dear Sean:

The purpose of this correspondence is to provide input to the National EMS Scope of Practice Model Draft 2.0 on behalf of the California Fire Chiefs' EMS Section. In general, the California Fire Chiefs are in support of the Model as presented. Specific issues that are supported include:

- The desire to establish this as a guideline and continue to support local control and variations based on the needs of local EMS agencies and providers
- Modifying the EMT status from certification to occupational licensure
- The roles and scope of practice of the Emergency Medical Responder (EMR), emergency Medical Technician (EMT), Advanced EMT and Paramedic are consistent with the vision of the Fire Chiefs' with minimal exceptions (see below).

The modifications suggested include:

- The addition of more practical analgesia options in the scope of practice of the Advanced EMT. This level of provider is needed in rural areas where paramedic resources may not be possible for a variety of reasons. Frequently, these are remote areas in which the transport of the patient may involve extended periods of time and the use of nitrous oxide is not a practical or effective modality for pain management.
- The elimination of the Advanced Practice Paramedic is not consistent with the NHTSA Vision of the Future. Forward thinking is needed given the current trend in medicine, specifically in emergency medicine where emergency departments are overburdened and closing in many urban settings. This growing problem is compounded with the many rural areas in which tertiary care may not be available. It is prudent to examine the use of paramedics to assist in these rapidly growing problem areas.

Thank you for the opportunity to provide this input.

Respectfully,

Mike Metro, President
California Fire Chiefs' EMS Section

Sean Trask

From: Lazarus, Kelly [Kelly.Lazarus@sbcphd.org]
Sent: Friday, May 20, 2005 10:22 AM
To: Dan Smiley
Cc: Sean Trask; Julie.Hamilton@emsa.ca.gov
Subject: Re: National EMS Scope 2.0

Dan,

Here are some comments back from the California Council of EMS Educators Committee regarding the National EMS Scope of Practice Model Version 2.0:

Page 6 - The Vison: *EMERGENCY Medical Services is just that - EMERGENCY "community based health management", "follow-up care", and "community health monitoring" are not part of and should not BE part of the EMS system. Talk about role creep!!!! This entire reference should be deleted as it is in direct contrast to what is written on pages 16 and 18, and what should be the direction of EMS *- p.16 says "For the protection of the public and to ensure pt safety, regulation must exist to prevent the tendency of the roles of EMS personnel to creep from their original intent."*

Page 18 *says "EMS delivers care as part of a system intended to attenuate the morbidity and mortality associated with sudden illnesses and injury" (my underline for emphasis)*

Page 13 *- paragraph 5, lines 33 - 38- good, insightful warning*

Page 14 *- Scope of Practice vs Standard of Care they deleted my favorite line -- "Central to the concept of scope of practice is individual responsibility" (what a concept! and they deleted it!!!)*

EMRs- *should be able to do spinal immobilize on a log board. Granted, moving the patient could be problematic, but they are already given manual stabilization and rapid extrication responsibilities w/in their scope. I think the concepts of long board spinal immobilization would not be foreign to them.*

EMTs*- pulse ox is one of those seemingly simple but really complex-in-understanding things warned about on page 13 (see above) to have people look at a number and say the patient is OK because the number is 95 is not quality care. Pulse ox has no use at the EMT level. On the other hand, even though poking a finger is invasive, I can see EMTs being more useful using a blood glucose monitor (or assisting pt/family with its use to determine a BGL).*

Advanced EMT*- this is where pulse ox belongs. I see this level being used only in those areas with long transports and limited personnel resources (i.e., low call volume &/or inability to afford EMT-P services)*

Paramedic*- Morgan lenses are barbaric w/o the use of a numbing medicine. And while I am not fond of the idea of any field person putting ANYTHING in a persons eyes besides NS of H2O, I can see the usefulness of the lenses to get a good flush of the eyes immediately. Synthetic blood products --MAYBE * as a stopgap measure, but the field is no place for real blood administration, and it is WAY beyond the scope of practice and trng for an EMT-P in any setting. C'mon, LVNs can't even give it w/o special certification, if at all. Blood chemistry analysis ??!?!? - and how is THAT useful in the field emergency setting ? (draw the bloods , sure, but what is the usefulness of a performing a blood chem panel in the field?). No doc in his right mind would treat off of the results of a test strip w/o a real chem panel as back-up, esp when (s)he does not know how the strips have been maintained/stored.*

ALL levels need to emphasize assessment skills & critical thinking

Page 28 - Specializations, I like how this is worded and the emphasis via italics for the last sentence.

If I get any more before next Wednesday, I will send them to you.

Talk to you soon,

Kelly

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Comments on the EMS Draft National Scope of Practice Model 2.0

The development of a National Scope of Practice Model is long overdue. This is important work and our California tri-county local EMS agency is grateful for the opportunity to comment on the second draft presented by the National Task Force.

Scope of practice should be driven by evidence of need and efficacy. These considerations should be inculcated among the prehospital personnel at every level of certification or licensure. It is essential to acknowledge both difficulty and the necessity, as well as the lost opportunity (in essential ongoing training for more beneficial interventions or the adoption of more promising skills or medications) represented by attempting to embrace every procedure or medication that might conceivably aid a patient.

Unfortunately, the Task Force risks foregoing a tremendous opportunity to model the type of sober reflection that they encourage in others. Although the document notes that "this project was guided by research whenever possible," and mentions NEMSIS and LEADS, nowhere does it explain how these sources influenced its deliberations or conclusions. This is particularly troubling as the LEADS project identified great dissatisfaction among prehospital care providers with their lack of career opportunity and the Task Force apparently disregarded this concern.

Nearly as puzzling is that the Ontario Prehospital Advanced Life Support study is nowhere referred to in the SOP Model. OPALS is the only broad authoritative study that correlates prehospital provider training (cost) to patient benefit. The omission of OPALS from the deliberations of the Task Force should be addressed in the final SOP Model.

In 2000, the American Heart Association upset many with new recommendations that veered sharply from the previous orthodoxy. Wisely the AHA published a thick tome (Guidelines 2000 for CPR and ECC) replete with the best evidence and clearly articulated the reasons for their decisions. The SOP Task Force speaks on behalf of the government of the United States of America. Regardless of the justifications offered, shortcuts and unexplained decisions made by the Task Force will be seen as arbitrary by many of those who may be asked to alter their previous practices as a result of the SOP Model. It is imperative that the results of the Task Force's deliberations be seen to rest on the best evidence, rather than a tally of the members' biases.

The paternalistic attitude revealed in the subtitle "Freedom within Limits" is echoed by the section entitled "The Risk of Role Creep." The need for a subtitle is dubious, and the one chosen seems intended to offend any thoughtful prehospital provider. The section entitled "The Risk of Role Creep" has no place in this document.

That the term "role creep" has survived to the second draft document is remarkable. Is this malaise indeed a phenomenon unique to EMS? In the US the most highly trained prehospital providers receive a little more than 1000 hours of instruction. Nevertheless there remains at once resistance to developing a more extensively trained prehospital provider, and consternation that the providers we have may be ill-equipped for the roles they are being asked to assume.

To date, the best evidence suggests that "paramedic discretion," or allowing prehospital care providers to triage patients in their homes, holds little promise. A closer reading of the data reveals that the paramedic is not being asked to out-guess the ED physician, but rather to divine the findings of the lab technician. Yet in California, it was just a few years ago that a gambit was made by these technicians to prevent field personnel from evaluating blood glucose levels. It is this type of turf protection that the Task Force is well positioned to quash. As patients, none of us

care to incur the expense and the discomfort of a trip to the ED. As medical professionals we should be open to any technological advance that eliminates the need for in-hospital evaluation or reduces the delay to definitive care. New technologies promise to allow cheap and rapid -and eventually field- evaluations of blood enzymes, for example. We should be preparing our prehospital personnel for this new world, rather than wringing our hands about the threat of "role creep."

"Supply and demand" is the mantra that underpins most of our political and economic life. If there is demand for prehospital personnel to fulfil new roles, should it be the business of the Task Force to thwart this evolution, to restrict the supply? It is a truism that prehospital personnel are often "placed into situations and roles for which they are not experientially or educationally prepared." Prepare them. At the very least, demand analysis of these "situations and roles" and determine a more sophisticated and long term approach than simply stringing razor wire.

If they are "numerous political, economic, social, and cultural reasons why personnel are pressured into functioning beyond their intended role," someone should explain which authority determined what these personnel were suppose to be up to? This fuzzy thinking does not belong in a document promulgated by a National Task Force.

Indeed EMS administrators expend much of their time fending off demands for the inclusion of new procedures and medications whose prehospital merits have not been demonstrated. Perhaps prehospital curricula need to invest more time in inculcating the Hippocratic oath and the humbling responsibility it places upon all those who aspire to helping their fellows.

The draft SOP Model does well to acknowledge the need for more EMS research in the section entitled "How to Use This Document." This section should be given higher priority. The document encourages more attention to "statistical analysis and research" among "the leadership of national associations, federal agencies, and research institutions." In fact the statistical analysis and research will only drive decision making when the actual practitioners, the prehospital personnel, acknowledge its importance.

The difficulties of collecting prehospital data and conducting research are compounded by the resistance of prehospital personnel. Until prehospital personnel "buy-in" to data, "the leadership" won't have much good data to go on. Without the understanding and acceptance of prehospital personnel, there will be little the leadership will be able to alter in current scopes of practice without protracted battles. Moreover, the type of data collection and analysis the current SOP draft document promotes cannot be done without more analytical expertise among prehospital providers who are the only ones "experientially" equipped to develop methodologies that adequately address the idiosyncrasies of the field environment. It is essential that the deliberations of the SOP Model lead to training curricula that develop a respect and understanding of evidence based medicine among every provider, at every level.

The list of members on the Task Force includes some of most progressive members of our national EMS leadership. These Task Force members have a unique opportunity to accomplish more than simply develop a scope of practice. The through its actions the Task Force can hasten the creation of prehospital practitioners who might someday make informed decisions about their own scope of practice. EMS has to grow up some day.

Louis Bruhnke, NREMT-P
Coordinator, North Coast EMS

Sean Trask

From: John Pritting [johnpritting@imperialcounty.net]
Sent: Wednesday, May 11, 2005 8:07 AM
To: Sean Trask
Subject: Re: National Scope Model Comments

Hi Sean
I support this matrix. I agree that there is very little demand anymore for the EMT-II level and the "Advanced" EMT meets the needs of rural areas more than the Intermediate EMT model. The EMT-II program met our needs initially as it filled the need to provide ALS in the more populated areas of the county (this was before we had a local paramedic program and EMTs had to travel out of county to attend paramedic training). The EMT-II program never met the need for early advanced care in the rural and wilderness areas because the initial training and continuing education requirements along with the cost were prohibitive for rural volunteer providers. The "Advanced" EMT program has met the needs of the rural volunteers by offering a training program that can be completed in 6-8 weeks at minimal cost to the provider. And the program offers the most bang for the buck by giving the providers a scope of practice that can be administered safely with minimal consequences while maximizing patient outcomes. The Advanced EMT program is also proving to be beneficial in supplementing ALS programs in urban areas. Teaming up and Advanced EMT with a paramedic offers a better combination than two paramedics (somewhat of a waste since one of them has to drive), and one paramedic with one basic EMT, since the Advanced EMT can assist the paramedic with some of the advanced interventions, while the basic EMT can only do BLS.

John Pritting
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----- Original Message -----
From: Sean Trask
To: 'Vicki Stevens (vicki.stevens@sdsheriff.org)' ; 'Tom McGinnis (mcginnist@hallamb.com)' ; 'Timothy Hennessy (THENN@so.cccounty.us)' ; 'Tim Williams (twilliams@co.fresno.ca.us)' ; 'Steven Tharratt MD (rstharratt@pacbell.net)' ; 'Stephanie Rasmussen (SRasmuss@ci.rancho-cucamonga.ca.us)' ; 'Ruth Grubb (ruthgrubb@ocfa.org)' ; 'Ron Grider (rgrider@norcalems.org)' ; 'Robert May (chief_may@burneyfireems.org)' ; 'Steve Drewniany (sdrewniany@ci.sunnyvale.ca.us)' ; 'Lawson Stewart (Lawson_Stewart@amr-ems.com)' ; 'Larry Karsteadt (execdir@northcoast.com)' ; Kevin White (kwhite@cpf.org) ; 'Kelly Lazarus (kelly.lazarus@sbcphd.org)' ; 'Kathy Ochoa (Kloseiu660@aol.com)' ; 'John Pritting (johnpritting@imperialcounty.net)' ; 'Janet Terlouw (janet.terlouw@sd.sheriff.org)' ; 'Howard Fincher (chief_may@burneyfireems.org)' ; 'Frank Maas (fmaas@mednet.ucla.edu)' ; 'Ed Prendergast (ed.prendergast@sdsherrif.org)' ; 'Debbie Becker (dbecker@co.fresno.ca.us)' ; 'Deb Aspling (daspling@lodihealth.org)' ; 'Darryl Cleveland (Darryl.Cleveland@ci.corona.ca.us)' ; 'Cliff Flud (Cflud@so.co.contra-costa.ca.us)' ; 'Chet Ward MD (traveldoc@sunset.net)' ; 'Bruce Haynes MD (Bhaynes@hca.co.orange.ca.us)' ; 'Bonny Martignoni (bmartign@co.napa.ca.us)'
Cc: Richard Watson ; Dan Smiley ; Nancy Steiner ; Julie Hamilton
Sent: Tuesday, May 10, 2005 3:39 PM
Subject: National Scope Model Comments

Dear EMT-II Task Force Members:
The purpose of this email is to remind the Task Force Members to submit their comments to me regarding the National Scope of Practice Model by May 25, 2005. Dan Smiley will bring the EMS constituents comments to the next meeting on June 1, 2005. I have attached a copy of the Version 2 of the National Scope of Practice Model in case you need it.

If you have any questions, please email me back.

Sincerely,

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